**EDUCATORS MUTUAL INSURANCE ASSOCIATION**

# FLEXIBLE SPENDING ACCOUNT ENROLLMENT/CHANGE FORM

852 Arrowhead Lane • Murray, UT 84107 • (801) 262-7475 • (800) 662-5851 • www.educatorsmutual.com

## Step 1: Employee Information

| | |
|---|---|
| Employer | Date of Hire |
| Employee's Name | Date of Birth |
| Street Address | Social Security Number |
| City, State, Zip | Home Telephone |
| Email Address | Work Telephone |

## Step 2: Contribution Agreement

If you are part of a company health insurance plan, your insurance premiums will automatically be paid pre-tax by payroll deduction. You may also choose any of the following benefits to add to your pre-tax deduction. There is an annual fee of $24 for this service. (Do not include insurance premiums in the Health Care contribution below.)

- ❑ Health Care (medical, dental, vision) $ _____ per year*
- ❑ Dependent Care (child, elderly) $ _____ per year*

Use the worksheet on the back of this form to help you calculate your estimated eligible expenses.

- ❑ Initial Request
- ❑ New Year Request
- ❑ Mid-year Request (Requires a qualifying event.)

## Step 3: Health Care Debit Card

A Health Care Debit Card allows you immediate access to your Health Care FSA funds. Receipts or other forms of substantiation may be requested at a later date. Would you like a Health Care Debit Card? There is an annual fee of $19.80 for this service.

❑ Yes ❑ No

## Step 4: Automatic Reimbursement

Automatic reimbursement is an option for employees who do not have coordination of benefits or the Health Care Debit Card. If eligible, do you want your processed Educators' claims automatically reimbursed?

❑ Yes ❑ No

## Step 5: Employee Signature

Choose One:

- ❑ **Enrollment:** I hereby request enrollment in the Flexible Spending Plan. I authorize my employer, until this authorization is revoked in writing due to a change in employment or family status, to reduce my gross salary by the appropriate amount. I understand that amounts contributed to the Flexible Spending Accounts are subject to forfeiture procedures under Section 125 of the Internal Revenue Code. I will only use the Health Care Debit Card for eligible expenses under the plan, and I understand that I will be responsible to pay for any transactions not allowed by the plan.
- ❑ **Waiver:** I understand that I am eligible to participate in the Flexible Spending Plan, but elect not to do so at this time. I also understand that I may participate in the Flexible Spending Plan during the next available enrollment period.

| | |
|---|---|
| Employee's Signature | Date |
| Employer's Signature | Date |

## Step 6: Optional Direct Deposit

You need only complete this portion of the application if you wish to have your FSA reimbursements deposited directly into your savings or checking account.

I hereby authorize Educators Mutual Insurance Association of Utah (EMIA) to deposit my Flexible Spending Account payments into my checking or savings account at my depository institution. This authority is to remain in effect until EMIA has received written notification from me that I wish to terminate the direct deposit benefit. I also agree to notify EMIA in writing within 30 days of any change in financial institution, account numbers, or status changes that may affect my eligibility to participate in Flexible Spending.

| | |
|---|---|
| Name of Financial Institution | Phone Number |
| Checking or Savings Account Number (Please include a voided check.) | Routing Number |
| Employee's Signature | Date |

**Please return completed form to your employer.**